STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	
		155655	B. WIN			04/25/2	011
	PROVIDER OR SUPPLIER			400 WE	ADDRESS, CITY, STATE, ZIP CODE EST SEVENTH STREET H MANCHESTER, IN46962	!	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	Complaint IN000 federal/state defi allegation are cit F-514. Survey date: Apr Facility number: Provider number AIM number: 10 Survey team:	089382 - Substantiated, ciencies related to the ed at F-281, F-323, and ril 25, 2011 000485 :: 155655	F0	000			
	DeAnn Mankell, R.N. Census bed type: SNF: 13 SNF/NF: 108 NF: 21 Residential 82 NCC: 13 Total: 237 Census payor type: Medicare: 19 Medicaid: 88 Other: 130 Total: 237 Sample: 4						
LABOR ATOR		/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L41Z11

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155655	B. WING			04/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			400 WE	ST SEVENTH STREET		
PEABOD	OY RETIREMENT C	OMMUNITY		NORTH	I MANCHESTER, IN46962		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΈ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	findings cited in 16.2.	es also reflect state accordance with 410 IAC pleted on April 28, 2011 by					
F0281 SS=D	facility must meet quality. Based on reconstruction interview, the ensure Certific (CNAs) worked of practice; in hot rice pack to shoulder result degree burn worksident. This 1 resident in a (identified as I A). Findings inclusion.	facility failed to ed Nurse Aides ed within their scope that a CNA applied a to a resident's ting in a second that a blister to the practice affected 1 of sample of 4. CNA RSC #2) and Resident ded: the "Indiana State Thealth Division of	F0	281	Preparation and execution of plan of correction in no way constitutes an admission or agreement by Peabody Retirement Community of the truth or of the facts alleged ir statement of deficiency and of correction. In fact, this pla correction is submitted exclusively to comply with stand federal law. Peabody Retirement Community reser the right to challenge in legal proceedings, all deficiencies, statements, findings, facts ar conclusions that form the bast the stated deficiency. This PI Correction serves as the allegation of compliance. Corrective action resident A:1) Policy related to application of moist/dry heat changedto reflect that only therapy staff will be allowed to apply heat modalities to residents. How other residents.	an e n this plan in of ate rves ind sis of lan of an of o was	04/26/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155655 04/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 400 WEST SEVENTH STREET PEABODY RETIREMENT COMMUNITY NORTH MANCHESTER, IN46962 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE with potential to be affected were Training Program dated July 1998 addressed:2) All residents having indicated.... Standard 14 Nurse rice packs in their rooms had the Aide Scope of Practice. The nurse new policy reviewed with them and the rice packs were removed aide will perform only the tasks in from resident the course standards and Resident rooms.Measures/system changes made:3) Policy was Care Procedures manual. The nurse amended. How corrective aide will not ... perform measures will be monitored:4) Nursing management has treatments...." included compliance on daily rounds sheets and will monitor for the next six months to ensure During the facility tour on 4/25/11 compliance. The policy will be at 11:07 A.M., with the ADON reviewed with all new nursing (Assistant Director of Nurses), she staff and SS will review with all new residents to ensure policy is indicated Resident A had a enforced. No heat packs being sustained a burn from a rice pack in discovered during rounds and no issues being brought up in the the past 3 to 4 weeks. safety committee for six months, indicating 100% compliance is the criteria that is needed in order to Resident A's clinical record was stop the monitoring, otherwise it reviewed on 4/25/11 at 2:30 P.M. will continue until compliance is achieved. This statement of deficiencies and POC dated Resident A's diagnoses included, 4/25/11 will be reviewed by but were not limited to, senile Peabody Retirement community QI/QA committee on May 25, dementia, hypertension, 2011 and the Safety committee osteoarthritis, hypothyroidism, on May 18, 2011. bipolar, and osteoporosis. The clinical notes for Resident A had a note, dated 3/31/2011 at 8:15 A.M., with the following: "Nurse noted 1.8 cm (centimeter) x 2.5 cm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655			ļ .	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/25/2	LETED
	ROVIDER OR SUPPLIER Y RETIREMENT CO		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE ST SEVENTH STREET MANCHESTER, IN46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	site on residen at 0700 [7:00 A RSC (resident [a certified numbag had been pushoulder last num	evas no blister. palpated pt (patient) c' could not determine n facial expression et, no grimacing. No ns/symptoms) of eed, no s/s infection Nurse Practitioner's dated 3/31/11, (second degree) burn. ne cream (a treatment pen blister/burn site day) until healed. (extra) dose of ain medication) prn					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/25/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST SEVENTH STREET I MANCHESTER, IN46962		
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR Review of the report, dated 3 Resident A had shoulder which cm with a blist. The brief description of the resident's should and resident had like it was burn immediately resident's should and resident had like it was burn immediately resident's should and resident had like it was burn immediately resident's should and resident had like it was burn immediately resident's should and resident had like it was burn immediately resident in the RSC's who unit on 3/30/11 RSC #2 noted pack for resident lunchtime because (complaining) shoulder. Statistically shoulder in the report in the report in the RSC's who unit on 3/30/11 RSC #2 noted pack for resident lunchtime because (complaining) shoulder. Statistically shoulder in the report in the re	DOMMUNITY TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) facility incident /31/11, indicated d a burn on her right h was 1.8 cm x 2.5 ter with erythema. ription was "RSC e that resident has a (R) shoulder. Per the bag was put on lder last night (3/30) and stated that it felt ning. Rice bag was temoved, site was red was present at that icated there were ws conducted with had worked on the l. The interview with "she heated up a rice tent shortly before ause she was c/o of pair to the R ed she heated it up	B. WIN	STREET A	ST SEVENTH STREET		(X5) COMPLETION DATE
		securely wrapped it and placed it on her R					

NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY (X4) ID PREFIX TAG Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain" STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962 STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962 STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962 ID PROVIDER PLAN OF CORRECTION COMPLETION DATE (X5) COMPLETION DATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain" 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962 (X5) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ACTION TO THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE DATE OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OF THE APPROPRIATE DATE OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OF THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRE			155655				04/25/2	011
PEABODY RETIREMENT COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain"	NAME OF I	PROVIDER OR SUPPLIER	. R	-			•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain (X5) D	PEAROL	Y RETIREMENT C	OMMUNITY		1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain PREFIX TAG PROVIDE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE COMPLETION DATE						110002		(X5)
Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain						(EACH CORRECTIVE ACTION SHOULD BE	TE.	
Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain	TAG			_	TAG			DATE
dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain		Review of the	policy for "Moist					
Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain		1 **	,					
P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain								
Peabody Retirement Community to use dry heat to relieve chronic pain		Administrator on 4/25/11 at 3:00						
use dry heat to relieve chronic pain		P.M., indicated "It is the policy of						
· I · ·		Peabody Retir	rement Community to					
		use dry heat to	relieve chronic pain					
and discomfort or in preparation for		and discomfor	t or in preparation for					
another treatment such as massage		another treatm	nent such as massage					
or stretching. Dry heat may be								
applied by a nurse as a nursing		applied by a m	urse as a nursing					
measure or with a physician's		measure or wi	th a physician's					
order."		order."						
During an interview with RSC #2,		During an inte	erview with RSC #2,					
who was a Restorative CNA, on		who was a Res	storative CNA, on					
4/25/11 at 6:00 P.M., she indicated		4/25/11 at 6:00	0 P.M., she indicated					
she had heated the rice pack in the		she had heated	d the rice pack in the					
microwave for 2 minutes and had		microwave for	r 2 minutes and had					
wrapped it in a towel and placed it		wrapped it in a	a towel and placed it					
on Resident A's left shoulder while								
the resident sat on a couch in the		the resident sa	at on a couch in the					
unit's common area. She indicated		unit's common	n area. She indicated					
she had also placed another rice		she had also pl	laced another rice					
pack on the resident's right groin.		pack on the res	sident's right groin.					
She indicated she had done this		She indicated	she had done this					
sometime between breakfast and		sometime bety	ween breakfast and					
lunch. She did not tell the nurse on		lunch. She did	d not tell the nurse on					
the unit and she could not		the unit and sh	ne could not					

PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155655			A. BUILI B. WING	DING	00	(X3) DATE S COMPL 04/25/20	ETED
	PROVIDER OR SUPPLIER			400 WES	DDRESS, CITY, STATE, ZIP CODE ST SEVENTH STREET MANCHESTER, IN46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	RSC's. She di unit after she h packs. She ind placed many r years she had a She indicated a how to heat th staff members During an inte Administrator P.M., she indicated policy had not	ne had told one of the d not remain on the had placed the rice dicated she had lice packs over the 6 worked at the facility. She had been told e rice packs by other in the past. In the past of the facility's been followed. In the past of the facility's been followed. In the past of the facility of					
F0323 SS=G	environment rema hazards as is poss receives adequate devices to prevent Based on reco		F03	323	Corrective action for resident A:1) Resident was assessed		04/26/2011
	ŕ	e use of rice packs for			immediately by nurse after be informed by RSC that resider		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: L41Z11

Facility ID:

000485

If continuation sheet

Page 7 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155655	B. WIN	IG		04/25/20)11
NAME OF	PROVIDER OR SUPPLIEF	₹	-		ADDRESS, CITY, STATE, ZIP CODE		
DEADOR	OV DETIDENTAL O	ON MALINITY		1	ST SEVENTH STREET		
PEABOL	DY RETIREMENT C	OMMUNITY		NORTH	MANCHESTER, IN46962		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	had a blister on her right		DATE
		dent complaints of			shoulder. Nurse practitioner	was	
	pain for 1 of 2	residents reviewed			contacted and she gave		
	for safe use of	Frice packs in the			treatment order for Silvaden	e	
	sample of 4.	This failure resulted			cream on 3/31/11 to open blister/burn twice daily until		
	_	sustaining a second			healed. Also, ordered extra	dose	
	degree burn to	-			of Tramadol for pain prn.		
	_	the shoulder.			Compliance date: 3/31/11Hc		
	(Resident A).				other residents with potentia be affected were addressed		
					Did 100% audit on all reside	· ·	
	Findings included: 1. During the facility tour on				who were using rice packs in		
					healthcare center. Assessed		
					head to toe. Found no other		
		07 A.M., with the			injuries to these residents. 2 Pulled all rice packs immedi		
					from resident's rooms after		
	`	tant Director of			explaining policy change.2c)		
	Nurses), she in	ndicated Resident A			Updated all nursing "hot she	ets"	
	had a sustaine	d a burn from a rice			for daily nursing charting to include any substantial skin		
	pack in the pa	st 3 to 4 weeks.			issues to be charted on ever	v l	
	1				shift until healed in nurses' n	otes.	
	Resident A's c	linical record was			Compliance date:		
		/25/11 at 2:30 P.M.			3/31/11Measures/system changes made:3a) All staff v	_{vas}	
	l reviewed on 4	123/11 at 2.30 P.MI.			informed on 4/1/11 that no h		
					dry or moist, would be perfor		
	Resident A's d	liagnoses included,			by any nursing staff. The PR		
	but were not 1	imited to, senile			therapy department will be the only staff who may apply	ne	
	dementia, hyp	ertension,			dry/moist heat to residents w	_{rith}	
	1	hypothyroidism,			heart modality physician ord	er	
	1				only.3b) When a resident de		
	bipolar, and o	steoporosis.			heat therapy, staff will give the resident other treatment opti		
					such as massage, ointments		
	Review of the	quarterly MDS			as ordered by the physician,		
	(minimum dat	a set) assessment,			referral to therapy for further		
	`	indicated a score of 8			assessment. Compliance da 4/1/11How corrective measu		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155655	B. WIN			04/25/2011
NAME OF I			_		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF E	PROVIDER OR SUPPLIER	•		400 WE	ST SEVENTH STREET	
	Y RETIREMENT C	OMMUNITY		NORTH	MANCHESTER, IN46962	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG		itive patterns which		TAG	will be monitored:4) The Dire	
		_			of Nursing or her designee w	rill
	indicated Resident A was moderately cognitively impaired.				complete rounds daily and	-11
					document findings to ensure significant skin issues are	all
					continuing to be charted on u	ıntil
	The clinical re	cord lacked any			resolved and placed on the "	hot
	nurses' notes f	rom 3/25/11 until			sheets" daily for the next six months. Significant skin issu	96
	3/31/11.				will be reviewed weekly at th	
					Risk meeting. No	
	The clinical notes for Resident A				documentation being determ to be missing after six month	
					and thus indicating 100%	13,
	had a note, dated 3/31/2011 at 8:15 A.M., with the following: "Nurse				compliance is the criteria tha	
	·	<u> </u>			needs to be met in order to s	•
	·	centimeter) x 2.5 cm			the monitoring, otherwise it v continue until compliance is	viii
	1	ythema surrounding			achieved.This statement of	
	site on residen	t's R (right) shoulder			deficiencies and POC dated	
	at 0700 today.	Per RSC (resident			4/25/2011 will be reviewed b Peabody Retirement commu	
	service coordi	nator [a certified			QI/QM committee on May	
	nurses' aid]), h	eated rice bag had			25,2011 and at the Safety	
	been placed or	resident's shoulder			committee on May 18, 2011.	
	1 ^	resident had c/o				
	· -	f) burning so bag was				
	l · -	emoved. Redness				
	1	ne site last night, but				
		lister. when (sic) site				
		ntient) states, 'it hurts,'				
		rmine pain level from				
		on due to flat affect,				
	_					
	no grimacing.					
		ms) of discomfort				
	noted, no s/s ii	nfection noted"				
	•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155655		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/25/2	ETED	
	PROVIDER OR SUPPLIER			400 WE	DDRESS, CITY, STATE, ZIP CODE ST SEVENTH STREET MANCHESTER, IN46962		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	progress note, indicated "20 of Apply Silvade for burns) to of bid (2 times a May give xtra Tramadol (a pramadol (nurse practitioner's dated 3/31/11, (second degree) burn. The cream (a treatment open blister/burn site day) until healed. (extra) dose of ain medication) promin." physician's order ack of an order for a MAR (Medication of the lack of of the use of the rice of the rice of the rice of the right of the was 1.8 cm x 2.5 ter with erythema. The right of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155655	B. WIN			04/25/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PEABOD	Y RETIREMENT C	OMMUNITY		1	EST SEVENTH STREET I MANCHESTER, IN46962		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	1
IAG		(R) shoulder. Per		IAG		DAIL	
	RSC heated rice bag was put on						
	resident's shoulder last night (3/30)						
	and resident had stated that it felt						
	like it was burning. Rice bag was						
	immediately re	emoved, site was red					
	1	was present at that					
	time."	1					
	The report contained a statement						
	made by RSC #1 indicated "On						
	1	d a rice pack on right					
		nch. Stated that she					
		burned her. Res					
	~	ust a little red so we					
	·	his morning on					
		getting the res ready					
		; I had seen it was					
		eported it to the					
	nurse."	eported it to the					
	nuise.						
	 There were nh	one interviews					
	1 ^	h the RSC's who had					
		unit on 3/30/11. The					
		RSC #2 noted "she					
	1	e pack for resident					
	l	lunchtime because					
	· '	omplaining) of pair to					
	the R shoulder	T. Stated she heated it					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		(X2) MI A. BUII		DNSTRUCTION 00	(X3) DATE S COMPL 04/25/20	ETED	
		100000	B. WIN		A DDDEGG CITY CTATE ZID CODE	04/25/20	J11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EST SEVENTH STREET		
PEABOD	Y RETIREMENT C	YTINUMMC			MANCHESTER, IN46962		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	COMPLETION DATE
	up for 3 minut	es, securely wrapped					
	it up in a towe	l and placed it on her					
	R shoulder."						
	Daview of the	nalisy for "Maist					
		policy for "Moist					
	Heat Application (Rice Packs), dated 5-04, and provided by the						
	· ·	on 4/25/11 at 3:00					
P.M., indicated "It is the policy of Peabody Retirement Community to							
	1	relieve chronic pain					
	1	t or in preparation for					
		ent such as massage					
		Dry heat may be					
	_	urse as a nursing					
	measure or wi	th a physician's					
	order." The pr	cocedure was 1. Use					
	microwave in	Medication Room					
	only to heat rid	ce packs. Place rice					
	pack in microv	wave on high for 11/2					
	- 2 minutes. 2	. Knead rick pack to					
	ensure equal d	istribution of the					
		rice pack in towels,					
		as necessary for the					
		resident 5. Assess					
	_	eat pack application					
		assessment on					
		Application Flow					
	Sheet which w	rill be placed on the					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S	ETED
		155655	B. WIN			04/25/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PEABOD	Y RETIREMENT CO	OMMUNITY			EST SEVENTH STREET I MANCHESTER, IN46962		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
1710		er 5 minutes, the	+	1710			DATE
		urse will remove the					
	pack and inspect the skin for redness or blistering. A pinkish hue						
	is normal. 9. At the end of the						
		area where the heat					
	was applied w	ill be inspected. The					
	skin assessmer	nt and response to					
	treatment will	be recorded on the					
	Hot/Cold Pack Application Flow						
	Sheet."						
	_	erview with RSC #2,					
		storative CNA, on					
		P.M., she indicated					
		I the rice pack in the					
		2 minutes and had					
		a towel and placed it					
		's left shoulder while					
		t on a couch in the					
		area. She indicated					
	_	laced another rice					
	_	sident's right groin. she had done this					
		veen breakfast and					
		d not tell the nurse on					
	the unit and sh						
		he had told one of the					
		d not remain on the					
	1.500 5. Dife til						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/25/2011		ETED		
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
PEABODY RETIREMENT COMMUNITY					ST SEVENTH STREET MANCHESTER, IN46962		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIA	TE	
	IN00089382. 3.1-45(a)(1)	ig relates to complaint					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
	155655 B. WING 04		04/25/2	04/25/2011			
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL				E	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.						
	information to ider the resident's asse and services provi preadmission scre State; and progres		ord of care				
	Based on recor	rd review and	F0	514	Corrective action for resident A:1) Updated all nursing "hot		04/26/2011
	interview, the	facility failed to have			sheets" for daily nursing char		
	a complete rec	ord of the care of a			to include all substantial skin		
	resident with t	he treatment of a rice			issues to be charted on every shift until healed in nurses'		
	pack for 1 of 1 resident with the use of a rice pack in a sample of 4			notes.How other residents with			
				■ •	potential to be affected were		
	(Resident A).	•			addressed:2) Nurse managers reviewed all "hot sheets" to ensure any current resident with		
	Findings inclu	ded:		substantial skin issue was included .Measures/system changes made:3) Updated a	all		
		the policy for "Moist on (Rice Packs)			nursing "hot sheets" for daily nursing charting to include al substantial skin issues to be		
		l provided by the			charted on every shift until he		
		on 4/25/11 at 3:00			in nurses' notes. How correct measures will be monitored:		
		I "It is the policy of			The Director of Nursing or he	er	
					designee will complete round daily and document findings		
	Peabody Retirement Community to use dry heat to relieve chronic pain				ensure all significant skin issues		
	-	-			are continuing to be charted on		
	and discomfort or in preparation for another treatment such as massage				until resolved and placed on the "hot sheets" daily for the next six months. Significant skin issues		
		ning. Dry heat may be					
		,			will be reviewed weekly at the Risk meeting. No		
	applied by a ni	urse as a nursing					

000485

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655			LDING	00	COMPLETED 04/25/2011		
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/20/2011	
NAME OF PROVIDER OR SUPPLIER				1	ST SEVENTH STREET		
PEABOD	Y RETIREMENT C	OMMUNITY	NORTH MANCHESTER, IN46962				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG		TE COMPLETION DATE	
1710		th a physician's	+	1710	documentation being determ		
		• •		to be missing after six months,		ıs,	
	1	rocedure was "5.			thus indicating 100% complia		
	_	ior to heat pack		is the criteria that n in order to stop the		I	
	application and				otherwise it will continue unt	il	
	assessment on Hot/Cold Pack Application Flow Sheet which will				compliance is achieved. This		
					statement of deficiencies and POC dated 4/25/2011 will be		
	be placed on the	he TAR. 9. At the			reviewed by Peabody Retire	• • • • • • • • • • • • • • • • • • •	
	end of the treatment, the area where				community QI/QM committed May 25,2011 and at the Safe		
	the heat was a	pplied will be			committee on May 18, 2011.	· .	
	inspected. The skin assessment and response to treatment will be recorded on the Hot/Cold Pack Application Flow Sheet."				•		
	During the fac	ility tour on 4/25/11					
	at 11:07 A.M.,	with the ADON					
	(Assistant Dire	ector of Nurses), she					
	indicated Resi	dent A had a					
	sustained a but	rn from a rice pack in					
	the past 3 to 4 weeks. Resident A's clinical record was						
	reviewed on 4	/25/11 at 2:30 P.M.					
	Resident A's d	iagnoses included,					
	but were not li	mited to, senile					
	dementia, hypertension,						
		hypothyroidism,					
	bipolar, and os						
	orporar, and or						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155655			(X2) M A. BUII		onstruction 00	(X3) DATE S COMPLI	
		B. WIN			04/25/20	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
PEABODY RETIREMENT COMMUNITY				1	EST SEVENTH STREET I MANCHESTER, IN46962		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DETCENCT)		DATE
ı	The clinical re	cord lacked any					
		rom 3/25/11 until					
	3/31/11.	10111 3/23/11 unui					
	3/31/11.						
	The TAR and	MAR for March 2011					
	lacked any ass	essment before or					
	*	f the rice pack.					
	1						
	The clinical record lacked a						
	Hot/Cold Pack Application Flow						
	Sheet.						
	The clinical no	otes for Resident A					
	had a note, dat	ted 3/31/2011 at 8:15					
	A.M., with the	following: "Nurse					
	noted 1.8 cm (centimeter) x 2.5 cm					
	blister with ery	ythema surrounding					
	site on resident's R (right) shoulder at 0700 [7:00 A.M.] today Per RSC (resident service coordinator [a certified nurses' aid]), heated rice bag had been placed on resident's						
		ight and resident had					
	c/o (complained of) burning so bag						
	was immediate						
	Redness was n	noted at the site last					
	night, but there	e was no blister.					
	when (sic) site	palpated pt (patient)					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
155655		A. BUILDING B. WING 00 04/25/2011				
NAME OF F	AD CLUDED OD CLUDE ED			ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER		l l	EST SEVENTH STREET		
PEABOD	Y RETIREMENT C	OMMUNITY	NORTH	MANCHESTER, IN46962		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
_		,' could not determine				
	•	n facial expression				
	*	ect, no grimacing. No				
		ns/symptoms) of				
	, -	ted, no s/s infection				
	noted"	, 10 5/5 1111001				
	 During an inte	rview with the				
	_	on 4/25/2011 at 5:30				
		cated there were no				
	additional notes about the rice pack.					
	uuuitioilui iiot	os docut me rice paeri.				
	This federal tag relates to complaint					
	IN00089382.					
	11(0000)302.					
	3.1-50(a)(1)					